

**ATTESTATION OF ENROLLMENT – CITY OF CINCINNATI EMPLOYEES
IN A NON-CITY OF CINCINNATI EMPLOYER GROUP HEALTH PLAN**

Return form to: Risk Management, 805 Central Avenue, Suite 100

Employee Name: _____ Work Phone: _____

City Employee ID: _____ Email: _____

This form applies to individuals who participate in the Integrated HRA and hereby waive enrollment in the City of Cincinnati Anthem 80/20 medical plan.

To participate in this program, employees, spouses/equal partners, and dependents must provide proof of enrollment in a non-City of Cincinnati employer group health plan. By signing below, I, a City Employee, certify that:

- The City of Cincinnati has offered me a group health plan (the Anthem 80/20 plan) that provides “minimum value” within the meaning of section 36B(c)(2)(C)(ii) of the Internal Revenue Code (basically a plan rated “bronze” or better under the Patient Protection and Affordable Care Act of 2010).
- I am enrolled in a group health plan of another employer (such as my spouse/equal partner’s employer) that provides “minimum value” within the meaning of section 36B(c)(2)(C)(ii) of the Internal Revenue Code (basically, “bronze” or higher) and that does not consist solely of a health reimbursement arrangement (HRA) under the Internal Revenue Code (that is, a plan that reimburses health care expenses only up to a dollar limit).
- I understand that by enrolling in this HRA, I am waiving participation in the City of Cincinnati Anthem 80/20 Plan.

For confirmation that the other plan meets the IRS's definition of minimum value and does not consist solely of an HRA, please contact the benefits coordinator at the other employer

Employee Signature

Date

Spouse’s Signature

Date

HRA information contact:
J & K CONSULTANTS, INC.
2605 Nicholson Rd., Suite 1140
Sewickley, PA 15143
Toll Free Phone: 877-872-4232
[**CinciHRA@JandKcons.com**](mailto:CinciHRA@JandKcons.com)
Toll Free Fax: 877-599-3724
[**Coc.JandKcons.com**](http://Coc.JandKcons.com)